the patient absolutely at rest for a long time after operation, so that the union of the deep structures may become firm enough to resist stretching, and the tendency to re-formation of hernia. After the patient gets up, it is well for him to wear a truss with a large soft pad, or some other form of support, for a few weeks or even months if practicable; but in my hospital cases I have found that a large pad, with elastic bandage adapted "spica" fashion, has been more convenient to the patient, and has answered the required purpose; and none of my cases (above referred to) wear any support now. It is obvious that in the case of sailors, marine firemen, and many classes of labourers, a truss is a nuisance, and often more likely to do harm than good. Hence the importance of striving to obtain a really permanent radical cure if possible.

There are many other points which I should have liked to mention, but this matter of prolonged rest appears to me to be one of the greatest importance, and about which very little has been said.

[I have omitted to mention that all of these operations were simply remedial; I have not included any cases of strangulated hernia.]

COMMENTS ON A CASE OF EXTREMELY ACUTE OEDEMATOUS LARYNGITIS.

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INSTANCES of acute laryngeal oedema are fortunately sufficiently rare to make it worth while to record the following case.

E. N., aged 30, housewife, the mother of seven children, which she had borne in as many years, was admitted under my care at the Bristol General Hospital on May 13th, 1886, with the following symptoms. I found her sitting up in bed, breathing with great rapidity and extreme difficulty, and very noisily; her face was pale, covered with perspiration, very anxious looking, lips livid. She had a frequent, short, almost toneless cough, which caused her much pain, and she expectorated stringy phlegm. She was compelled to swallow mucus and saliva very frequently, spite of her wish to spare herself the pain which this occasioned. Her voice was reduced to a whisper. Even the gentlest manipulation of the larynx provoked so much spasm and dyspnoea that I speedily desisted, but I was able to feel that it was thicker and more fixed than is normally the case. The heart, lungs, and kidneys were healthy. Temperature 104.2° F. On examining the pharynx and fauces, they were seen to be moderately congested. With the laryngoscope the epiglottis was seen to be extremely oedematous, being turgid, erect, and glistening, almost touching the back of the tongue, and its sides so nearly came into contact that a space, capable of admitting a small catheter, was all that was left open.

I ordered a rapid succession of hot poultices to the larynx, had a large croup-tent rigged up, with plenty of steam impregnated with compound tincture of benzoin going into it, and nutrient enemata every four hours. The temperature in the evening was 102°.

May 14th. She had had a sleepless night owing to pain and cough; she was breathing rather better, had expectorated a very large quantity of tenacious mucus; the epiglottis could be seen to be less oedematous, and the posterior part of the glottis was visible and did not appear swollen, nor was the small extent of the vocal cords that could be seen congested. Temperature 102.6°, evening temperature 104.2°.

May 15th. Everything had improved; the epiglottis was markedly smaller, and a good deal of glottis was visible. I could now satisfy myself that the cords were not congested, nor was there oedema of the mucous membrane covering the arytenoids, nor of that between them, nor were the aryepiglottic folds enlarged; the ventricular bands, however, were redder and thicker than usual. The voice had some tone in it. Nutrient enemata were now stopped. As the epiglottis was able to move and to act as a guard to the larynx, I gave her some moderate doses of quinine. Temperature 100.8°, evening temperature 103.2°.

May 16th. Everything better still, had had a fairly good night; the voice had much more tone in it, but was still feeble. Temperature 100.2°. Tent, steam kettle, and poultices were all discontinued, but she got an occasional inhalation of tinct. benzoin co. Evening temperature 97.8.

From this time the patient made a slow but sure recovery, and was dismissed on June 7th, 1886, quite well.

Previous to this illness the patient had been very healthy, and there was no history of syphilis, but she considered that she had been much pulled down by her rapid child-bearing. For two months immediately preceding her admission to hospital, she had had a cold, with no sore throat nor cough sufficient to induce her to seek medical

aid. On the morning of the day on which I first saw her she got up as usual, and had breakfast, and not until 10 A.M. did she feel any trouble in her throat. She then experienced acute pain in her right ear, which lasted an hour; this subsided, and she was attacked by hoarseness and difficulty in breathing, both of which symptoms steadily got worse, until about 1 P.M. I found her in the serious condition that I have described.

I consider that the case presents several points of much interest.

1. *The Extreme Rapidity of Onset.*—Rarely, I believe, has a more acute oedematous laryngitis of non-traumatic origin been recorded, since only about three hours elapsed between the first feeling of pain in the ear, and the terrible state in which I found her. This for an idiopathic case is worthy of remark.

2. *Its Etiology.*—The woman's kidneys, heart, and lungs were healthy. She had had no recent attack of scarlatina, rheumatism, syphilis, erysipelas, nor, in fact, anything which we could consider preceded the throat attack; it was, in other words, a primary oedematous laryngitis. It was not consecutive to any disease of cartilages or their coverings, as we sometimes see. It was, I believe, a case of contiguous oedematous laryngitis, which spread from a merely trifling pharyngeal congestion, in a woman debilitated by rapid child-bearing and by "cold in the head," with the accompanying feverishness, etc., from which she had suffered for two months previously.

The aphonia was probably due to the fact that the muscles (adductors and tensors) were parietic owing to the contiguous inflammation, and in all probability there was a greater or less amount of serum dispersed amongst their fibres. The nerves supplying them would be crippled in the same way, whilst the swelling of the ventricular bands and the great enlargement of the epiglottis would assist in deadening any sound that might be produced in the larynx. The weight of the thickened superincumbent epiglottis would also impede the action of the muscles concerned in phonation.

It is just in such cases that scarification is by some specialists considered the only proper treatment; but when I looked at the extremely small orifice left between the sides of the swollen epiglottis, and thought of the effect of liberating thick exudation, I was so afraid that an immediate suffocative attack would ensue that I resolved to try other measures. I would lay stress on feeding by nutrient enemata, because, owing to the inability of the epiglottis to cover the top of the larynx had the patient taken food by the mouth, a certain amount of it must have got into the air-passages.

CLINICAL MEMORANDA.

INFECTIVE ENDOCARDITIS WITH MULTIPLE EMBOLISMS IN THE SKIN.

M. H., a pale, delicate nurse, aged 20, had been frequently noticed since she first entered service six weeks previously to breathe in a short, quick, gasping fashion, when she suddenly became seriously ill, shivering, vomiting, sleeping very heavily, and complaining of severe headache and great weakness. There had been no recent rheumatism, but of her previous history nothing was known. She had been laid up three days when she first came under my care.

I found her lying on her back, muttering and rambling, occasionally vomiting, sometimes crying out with pain in her feet, hands, legs, abdomen, or back. Her lips, teeth, tongue and palate were black with sordes, the edges of the tongue ulcerated; the abdomen was distended and tender; there was a heaving impulse, and an aortic systolic *bruit*. She remained under observation three days before dying, and throughout that period her temperature, taken every four hours, lay between 102° and 105°, usually about 103°, the pulse between 140 and 160, the respirations between 25 and 40, becoming more and more laboured towards the end; the motions, passed voluntarily, were relaxed, green, and offensive; the urine, also passed voluntarily until the last twelve hours, was dark, acid, specific gravity 1020, with plenty of urates, and one-fifth albumen.

But the chief interest in the case lay in the state of the skin. On the chest were four or five small, not raised scarlet hæmorrhages, and one of a duller purple, all corresponding in size to those commonly seen in typhus; on the back was a non-umbilicated pustule of the size of a split pea; on the fronts and inner sides of the thighs were purplish blotches about the size of various coins, and on the shins and feet were some larger bright red blotches like commencing chilblains; on the left forearm were a few ill-defined bright-pink petechiæ; at the tips of the thumbs and fingers and toes were numerous vesicles, some transparent and colourless, others purple from hæmorrhage, not raised above the surface, but producing great tension, swelling, tender-